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# HEADACHE/MIGRAINE HISTORY & ASSESSMENT FORM

***Forms must be completed in their ENTIRETY***
****Bring a list of your MEDICATIONS***

## PERSONAL HISTORY

Date: _____

Last Name: _____ First Name: _____

**Date of Birth:** D _____M _____YR _____ **Age**: _____ Height _____ Weight _____ Sex: M / F / Other

**OHIP (health card) #:** _____ **Version Code:** _____ Preferred Pharmacy: _____

Address: _____ City/Town:_____ Postal Code: _____

Telephone: (_____) _____ Cell: (_____) _____ Work: (_____) _____

Preference of which number to call you: *(please circle)* HOME / CELL / WORK May we leave a voicemail? YES / NO

***Email:** _____ Occupation: _____

**Do you have a private / extended healthcare plan? Y / N** Name of provider(s): _____

## MEDICAL HISTORY

Family Physician: _____ Address: _____

Are you currently **pregnant or breastfeeding**? **Y / N** Are you planning a **pregnancy** within the next year? **Y / N**

**Major illnesses or Surgeries** [PAST or PRESENT] ( cancer, diabetes, surgery, etc. ): _____

_____

Do you have any **upcoming/planned procedures/surgeries? Y / N** _____

Do you have any **neurological** conditions? [i.e. myasthenia gravis, multiple sclerosis, ALS, Lambert-Eaton syndrome, Bells Palsy, etc.] **Y / N**

**Current health conditions/diagnoses** (please include *everything*, even if you may feel it is not relevant/significant): _____

_____

_____

Please list any **current medications** including vitamins, herbal supplements (include dosage if able): _____

_____

_____

Are you taking **blood thinners** [ anti-coagulant or anti-platelet medications ]? **Y / N** If yes, please explain: _____

Please list any **Allergies** [ foods, medication, environmental, other ]: _____

Do you smoke? **Y / N** How much/often? _____

Have you ever used botox before? **Y / N** How so? (please circle): Medically Cosmetically

**You may NOT have Botox if you are pregnant, breastfeeding, or during the first three months following delivery.**

# HEADACHE HISTORY

*(Please note: Any type of headache counts during the following questions, not just the ones you may consider "migraines". Days when headaches were successfully treated with migraine-specific acute medications (e.g. triptans) are also considered headache days.)*

**Onset:**

At what age did the headaches start? Age: _____ How long have you suffered with headaches? _____

**Frequency of headaches:**

In the last month (past 30 days), on how many days did you have a headache? _____

In the last 3 months (past 90 days), on how many days did you have a headache? _____

***If you cannot recall how many headache days you have had, try counting the number of **headache-FREE** days to help you determine.*

**Duration of headaches:**

How long do your headaches usually last? (please circle) Minutes Hours Days

If you chose hours or days, **how many hours at a time** do your headaches usually last? _____ hours

**Intensity of headaches:**

How often was the pain moderate to severe? Never Rarely Less than half the time More than half the time

Rate the worst headaches on a scale from **0 - 10** (0=no pain, 10=worst pain ever): _____ out of 10

**Character/Features of headaches (past 30 days):** (please circle)

Sensitive to light (felt more comfortable in a dark place)? Never Rarely Less than half the time More than half the time

Sensitive to sound (felt more comfortable in a quiet place)? Never Rarely Less than half the time More than half the time

How often did you feel nauseated/sick to your stomach? Never Rarely Less than half the time More than half the time

Area of headache: Front of head/back of head One-side of head only Both sides of head

Describe how it feels: Throbbing Sharp/stabbing Pressure/Squeezing

Pulsatile Tension Dull ache

Please circle any other symptoms you have experienced: Vomiting Inability to work/function Other: _____

Presence of Aura? **Y / N** *(Aura: sensory disturbances can include: flashes of light, blind spots, vision changes or tingling in your hand/face).*

*Please describe:* _____

During headaches, do you experience any pain in other areas/muscles? (jaw, eyes, ears, neck, shoulder, etc) **Y / N** If so, please explain:

_____

**Aggravating factors/triggers:** (circle all that apply)

Physical activity Mental exertion/concentration Computer use/eye strain Stress Sleep depravation Driving

Trauma Dehydration Diet ( *chocolate / alcohol / caffeine / cheese / spices or flavourings* ) Weather Other: _____

**Medication use (past 30 days):**

How many days did you use over-the-counter medications to treat your headache attacks? _____

How many days did you use prescription medications to treat your headache attacks? _____

**Previous diagnostic investigations:** (please circle)

Have you had any of the following investigations/tests completed in the past year? CT Scan MRI Sleep test/study

Ophthalmological testing

Emergency room visits related to headaches? # of visits _____

**Epworth Sleepiness Scale**

How likely are you to doze off or fall asleep in the following situations, in comparison to feeling just tired?

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

| Situation | Chance of dozing (0 = low, 3 = high) |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting still in a public place (e.g. a theatre, a cinema or a meeting) | |
| As a passenger in a car for an hour without a break | |
| Lying down to rest in the afternoon when the circumstances allow | |
| Sitting and talking to someone | |
| Sitting quietly after lunch without having drunk alcohol | |
| In a car or bus while stopped for a few minutes in traffic | |
| **TOTAL** | |

| **PHQ9**<br>**Over the last <u>two weeks</u> how often have you been bothered by the following problems?** | | **0**<br>Not at all | **1**<br>Several Days | **2**<br>More than half the days | **3**<br>Nearly every day |
|---|---|---|---|---|---|
| A | Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| B | Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| C | Trouble falling or staying asleep, sleeping too much | ☐ | ☐ | ☐ | ☐ |
| D | Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| E | Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| F | Feeling bad about yourself – or that you are a failure or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| G | Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| H | Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| I | Thoughts that you would be better off dead or of hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |
| Severity Score | Mild depression = 5 – 10<br>Moderate depression = 10 – 18<br>Severe depression = 19 – 27 | Total Score: | | | |
| | If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

| GAD7<br>Over the last two weeks how often have you been bothered by the following problems? | 0<br>Not at all | 1<br>Several Days | 2<br>Over than half the days | 3<br>Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | ☐ | ☐ | ☐ | ☐ |
| Not being able to stop or control worrying | ☐ | ☐ | ☐ | ☐ |
| Worrying too much about different things | ☐ | ☐ | ☐ | ☐ |
| Trouble relaxing | ☐ | ☐ | ☐ | ☐ |
| Being so restless that it's hard to sit still | ☐ | ☐ | ☐ | ☐ |
| Becoming easily annoyed or irritable | ☐ | ☐ | ☐ | ☐ |
| Feeling afraid as if something awful might happen | ☐ | ☐ | ☐ | ☐ |
| Total Score (add your column scores) | | | | |
| If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

# HIT-6™

(VERSION 1.1)

HEADACHE IMPACT TEST™

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.

1. When you have headaches, how often is the pain severe?

Never | Rarely | Sometimes | Very Often | Always

2. How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

Never | Rarely | Sometimes | Very Often | Always

3. When you have a headache, how often do you wish you could lie down?

Never | Rarely | Sometimes | Very Often | Always

4. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

Never | Rarely | Sometimes | Very Often | Always

5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never | Rarely | Sometimes | Very Often | Always

6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never | Rarely | Sometimes | Very Often | Always

▼ COLUMN 1 (6 points each) + ▼ COLUMN 2 (8 points each) + ▼ COLUMN 3 (10 points each) + ▼ COLUMN 4 (11 points each) + ▼ COLUMN 5 (13 points each)

**To score, add points for answers in each column.**

Please share your HIT-6 results with your doctor.

Total Score ____

Higher scores indicate greater impact on your life.

Score range is 36-78.

## The Migraine Disability Assessment Test

The **MIDAS** (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

**INSTRUCTIONS**

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

_____ 1. On how many days in the last 3 months did you miss work or school because of your headaches?

_____ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

_____ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

_____ 4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

_____ 5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

_____ Total (Questions 1-5)

**Scoring:** After you have filled out this questionnaire, add the total number of days from questions 1-5

| MIDAS Grade | Definition | MIDAS Score |
|---|---|---|
| I | Little or No Disability | 0-5 |
| II | Mild Disability | 6-10 |
| III | Moderate Disability | 11-20 |
| IV | Severe Disability | 21+ |

**Other previous treatments attempted/used previously?:** (please circle)

Occipital nerve block  Opioids  Massage Therapy  Chiropractic Therapy  Acupuncture  Physiotherapy

Other: _____

# MEDICATION - *MUST BE COMPLETED*

**Please LIST ALL medications you have tried for migraines / headaches (past & present).**

You must include: **name** of drug, **dose** of drug (how many mg, how many times per day), **how long** you tried it for (days, months, years) & tell us **why you stopped using it or if you are still using it**. *For insurance purposes, this *may* be cross-referenced with your pharmacy/medical records.

| **Medication** (name of drug) | **Dosing** (how much; how often) | **Start Date & End Date** | **Results/Outcome** (Intolerable side effects, ineffective, etc) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

*Use the medication example charts below to see if you recognize any of these medications that may have been used.*

**Prophylactic/Preventative Examples**

| Antidepressants | Antiepileptics/ Anticonvulsants | Beta-blockers | Calcium Channel Blockers | Angiotensin-Converting Enzyme (ACE) Inhibitors/ Angiotensin II Receptor Blockers (ARB) |
|---|---|---|---|---|
| Amitriptyline | Divalproex sodium | Atenolol | Diltiazem | Candesartan |
| Citalopram | Gabapentin | Metoprolol | Nifedipine | Enalapril |
| Doxepin | Topiramate | Nadolol | Nimodipine | Irbesartan |
| Fluoxetine | Valproic acid | Propranolol | Verapamil | Lisinopril |
| Bupropion (Wellbutrin) | Pregabalin (Lyrica) | Timolol | | Losartan |
| Mirtazapine | | | | Olmesartan |
| Nortriptyline | | | | Ramipril |
| Paroxetine | | | | Valsartan |
| Duloxetine | | | | |
| Sertraline | | | | |
| Venlafaxine | | | | |

| Gepants | Monoclonal Antibodies |
|---|---|
| Ubrelvy | Aimovig |
| Nurtec | Ajovy |
| Qulipta | Emgality |
| Zavzpret | Vyepti |

**Acute/Abortive Examples**

| NSAIDs/ Analgesics | Ergot Alkaloid Derivative | Triptans | Combination/Other |
|---|---|---|---|
| Acetaminophen / Tylenol | Ergotamine | Almotriptan | Acetaminophen/aspirin/caffeine (Tylenol#3) |
| Aspirin | Dihydroergotamine (DHE) | Eletriptan | Butalbital/acetaminophen/caffeine (Fioricet) |
| Diclofenac (Cambia) | | Frovatriptan | Butalbital/aspirin/caffeine (Fiorinal) |
| Ibuprofen / Advil | | Naratriptan | Butorphanol |
| Naproxen | | Rizatriptan | Ergotamine/caffeine |
| | | Sumatriptan | Sumatriptan/naproxen (Suvexx) |
| | | Zolmitriptan | |

## *PATIENT - PLEASE SIGN* - AUTHORIZATION OF INFORMATION

I have carefully read all **9** pages of this document *(including the Medication page)* and confirm that the above/below stated/written information and disclosure of my personal health information is correct to the best of my knowledge.

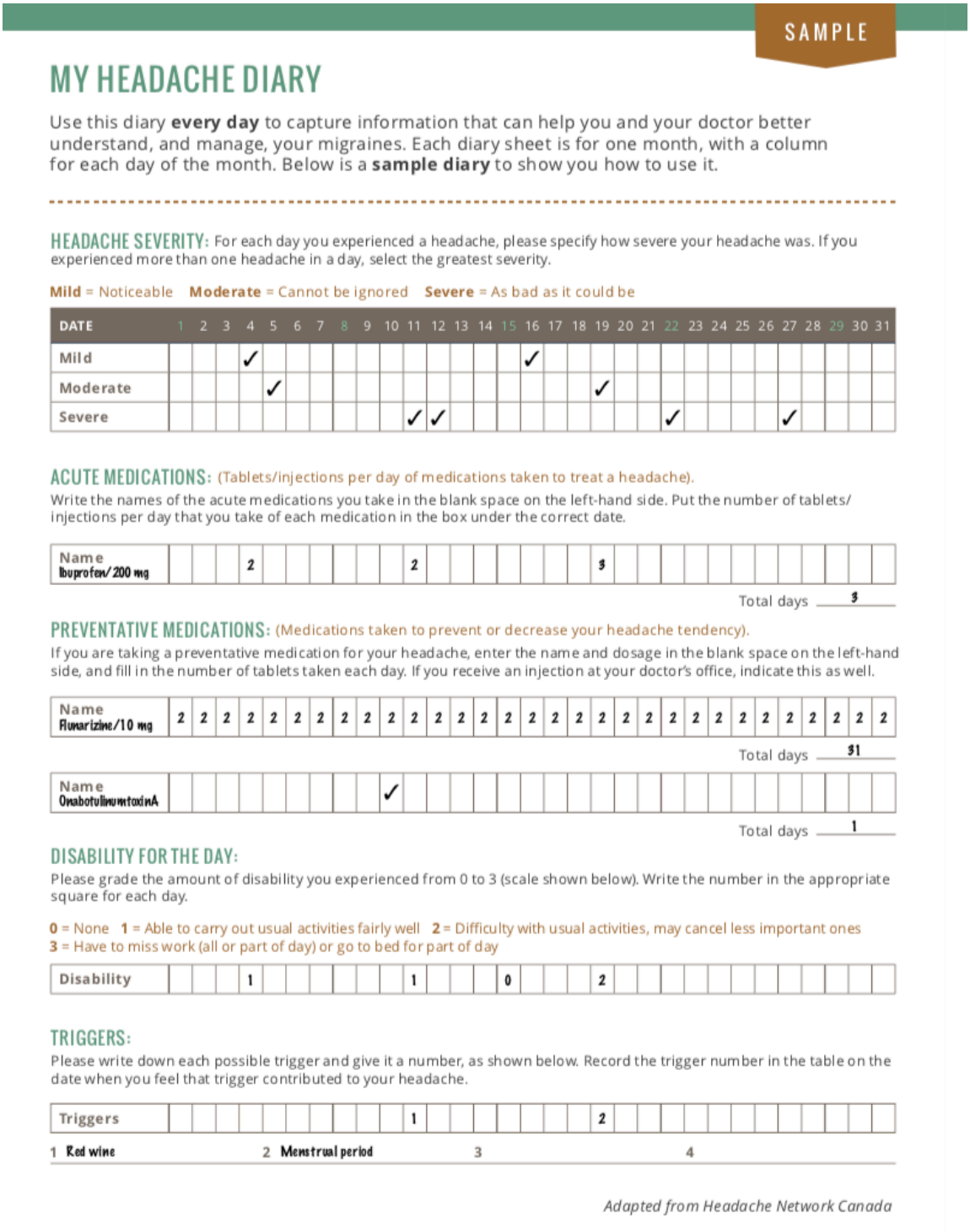
Patient Signature: _____

Print Name: _____

# Note Regarding Private Insurance / Private Benefit Coverage of BOTOX MIGRAINE TREATMENT

- The administration of Botulinum Toxin for cosmetic purposes is strictly excluded from coverage.
- BOTOX MIGRAINE TREATMENT is not currently covered by OHIP.
- The cost of the drug itself (Botox Therapeutic) may be covered by some private insurance providers. **If you do not have private insurance, the entire cost is then paid privately by the patient. However, we do have access to a small amount of assistance (up to 20% of the cost of the drug, for a limited number of treatments per year) through a Patient Support Program if you do not have private coverage.*
- The "Injection Fee" of $175 (+tax) is payable upon each treatment to the CLINIC (this is not covered by insurance).
- Each private insurance/benefit provider may have different criteria and requirements before consideration of covering BOTOX MIGRAINE TREATMENT.
- BOTOX MIGRAINE TREATMENT is considered a specialty therapy. Trials of "first tier" treatment (preventative oral medications) are required prior to consideration of approval for BOTOX MIGRAINE TREATMENT.
- Typically, in order to qualify for coverage of BOTOX MIGRAINE TREATMENT, you must meet certain criteria:
    - Have a diagnosis of Chronic Migraine (from your family doctor, neurologist, or Dr Tetelbaum can help determine this). The diagnosis of Chronic Migraine is defined as having 15 days or more of headaches per month (for at least the past 3 months) of which 8 days of the month were migraines days (lasting 4+ hours).
    - Have tried at least 2 (sometimes 3, depending upon insurance provider) different trials of prophylactic medications (from an approved list) for the prevention of CHRONIC MIGRAINE.
    - Medication Trials: These trials can vary from 6 - 12 weeks in length. If a trial is failed, we move on to the next trial (and so on, until the insurance criteria has been fulfilled). **A failed trial may be considered if:*
        - Unsatisfactory or no therapeutic effect (less than 30% reduction in frequency of headache days) to an adequate dose/duration of the prophylactic medication.
        - Contraindication or intolerable side effects necessitating discontinuation (depending upon insurance provider, this may only be considered for 1 of the drugs only).
    - Prophylactic (preventative) medication trials do not include ACUTE medications such as triptans, NSAIDS or OTC pain medications.
    - There is a specific list of "accepted"/approved medication types that can be used for prophylaxis. These may include (but are not limited to): topiramate, divalproex sodium/valproate sodium, beta-blockers (metoprolol, propanolol, timolol, atenolol, nadolol), tricyclic anti-depressants (amitriptyline, nortriptyline), SNRIs (venlafaxine, duloxetine), angiotensin receptor blockers (candesartan).

- Patients are required to keep a log book or tracking journal to document their headaches. Visit [mychronicmigraine.ca](mychronicmigraine.ca) to print copies of an excellent example of a "Headache Journal". See example below:



SAMPLE

## MY HEADACHE DIARY

Use this diary **every day** to capture information that can help you and your doctor better understand, and manage, your migraines. Each diary sheet is for one month, with a column for each day of the month. Below is a **sample diary** to show you how to use it.

**HEADACHE SEVERITY:** For each day you experienced a headache, please specify how severe your headache was. If you experienced more than one headache in a day, select the greatest severity.

**Mild** = Noticeable **Moderate** = Cannot be ignored **Severe** = As bad as it could be

| DATE | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mild | | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | |
| Moderate | | | | | ✓ | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | |
| Severe | | | | | | | | | | | ✓ | ✓ | | | | | | | | | | ✓ | | | | | ✓ | | | | |

**ACUTE MEDICATIONS:** (Tablets/injections per day of medications taken to treat a headache).

Write the names of the acute medications you take in the blank space on the left-hand side. Put the number of tablets/ injections per day that you take of each medication in the box under the correct date.

| Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ibuprofen/200 mg | | | | 2 | | | | | | | 2 | | | | | | | | 3 | | | | | | | | | | | | |

Total days 3

**PREVENTATIVE MEDICATIONS:** (Medications taken to prevent or decrease your headache tendency).

If you are taking a preventative medication for your headache, enter the name and dosage in the blank space on the left-hand side, and fill in the number of tablets taken each day. If you receive an injection at your doctor's office, indicate this as well.

| Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Flunarizine/10 mg | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |

Total days 31

| Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| OnabotulinumtoxinA | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | |

Total days 1

**DISABILITY FOR THE DAY:**

Please grade the amount of disability you experienced from 0 to 3 (scale shown below). Write the number in the appropriate square for each day.

**0** = None **1** = Able to carry out usual activities fairly well **2** = Difficulty with usual activities, may cancel less important ones
**3** = Have to miss work (all or part of day) or go to bed for part of day

| Disability | | | | 1 | | | | | | 1 | | | | 0 | | | | 2 | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**TRIGGERS:**

Please write down each possible trigger and give it a number, as shown below. Record the trigger number in the table on the date when you feel that trigger contributed to your headache.

| Triggers | | | | | | | | | | | 1 | | | | | | | | 2 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

1 Red wine 2 Menstrual period 3 4

*Adapted from Headache Network Canada*